

Some Red Rules Shouldn't Rule In Hospitals

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As health care strives to create a culture of safety, many organizations are successfully incorporating safety practices mentioned in past columns in *P&T* and used in highly reliable industries, including failure mode and effects analysis, root cause analyses, redundancies with technology, and crew resource management. These strategies have been adopted to help organizations reduce the risk of patient harm from preventable adverse events.

Recently, another safety practice used by highly reliable industries—known as red rules—has sparked interest in health care, and some organizations have begun to adopt this strategy.

DEFINING RED RULES

Red rules are rules that cannot be broken. In highly reliable industries, these rules are few in number, are easy to remember, and are associated only with processes that can cause serious harm to employees, customers, or the product line. Red rules must be followed exactly as specified except in rare or urgent situations. Every worker, regardless of rank or experience in the company, is expected to stop the work or the production line if a red rule is violated. This is the most important aspect of a red rule: to empower all workers to speak up when the rule is not being followed and to “stop the line,” regardless of their position or seniority.

Foremost, management always supports the work stoppage when a red rule is violated, no matter how inconvenient, expensive, or disruptive to the company it might be. Furthermore, all violations of a red rule are mediated through a “just culture” approach in which the worker’s behavioral choice—in this case, breaking

a red rule—is evaluated to determine whether the breach was caused by human error, at-risk behavior, or reckless behavior, regardless of the staff member’s rank, popularity, or importance to the company.

Red rules should not be used as a means to discipline workers for breaking particular rules; they should serve as a way to empower the entire workforce to take action if a critical rule is broken. As with any rule, repeated violations of a red rule should spur an evaluation of internal systems that might have made it difficult to follow the rule.

RED RULES IN INDUSTRY

In companies that use a production line to assemble a product, a red rule might be associated with a crucial component that, if defective, could lead to significant harm to employees or customers. Inspecting the component before placing it on the assembly line would be the red rule, and anyone who notices that the component has not been inspected or has not passed the inspection, according to specifications, would be given the authority and responsibility to stop the line until the component has been inspected or replaced, even if it is inconvenient or financially costly to the company. The company’s adoption of this red rule conveys the message that safety is of the utmost importance.

RED RULES IN EVERYDAY LIFE

The use of seatbelts in an automobile is an example of a red rule that everyone should follow. If an individual is not buckled up when the automobile pulls out, any driver or passenger in the car should have the opportunity to speak up, tell the individual who is not wearing a seatbelt to buckle up, and allow the vehicle to stop until the action is completed. Maybe the individual was preoccupied and forgot this important step (human error) or was in the habit of failing to follow this safety rule (at-risk behavior). This doesn’t mean that the person must be ex-

pelled from the car for breaking the rule. If the individual decided to purposely refuse to wear a seatbelt for personal convenience, knowing the risk, disciplinary action might be warranted.

CRITERIA FOR RED RULES

How do an organization’s red rules differ from other crucial rules, policies, or procedures? It must be possible and desirable every time for everyone to follow a red rule under all circumstances. Red rules should not contain phrasing such as “except when...” or “each breach will be assessed for appropriateness.”

Anyone in a health care organization who notices that a red rule has been breached may, and should, stop further patient care associated with the red rule in order to protect the patient or employee from harm.

Managers and leaders, including the board of trustees, should always support the work stoppage and should immediately begin correcting the problem and addressing the reason for breaking the rule.

The people who breached the red rule should be given an opportunity to support their choices. They are then judged fairly based on the reasons for breaking the rule, regardless of their job level or experience.

The red rules should be few in number, understood by everyone, and memorable.

RED RULES IN HEALTH CARE

In any workplace, a few rules are well understood by all and are never intended to be broken under any circumstance by anyone.¹ These rules often stem from well-established societal norms, such as not causing harm to others. In health care, this can be translated into strict avoidance of patient abuse, sexual harassment, or working under the influence of alcohol or drugs. Certainly, these and similar societal norms can be considered red rules, because there are no reasonable circumstances under which



the rules can be broken. Beyond these societal norms, however, the appropriate use of red rules in health care should be limited to those that can always be followed and, if broken, can cause significant harm. Following are two examples.

1. Reconciling a sponge count. During surgery, reconciling the number of sponges and instruments before an incision is closed might be considered a red rule. If a surgeon starts to close an incision before the count is reconciled (a breach of the red rule), everyone in the room, without exception, would be permitted (and would be held responsible) to halt the process until reconciliation occurs. Thus, the organization's leaders must gain consensus from the clinical staff, particularly the surgeons, that closing an incision—despite an incorrect count—puts patients at greater risk than failing to close the incision while reconciling an incorrect count. Leaders must also be willing to hold physicians who breached the red rule accountable for their behavioral choice, judge the physician fairly based on the reason for breaking the rule, and support staff members who stopped the process of the closure.

2. Instituting a time-out before an invasive procedure. If holding a time-out to verify the patient and the site of surgery before the start of a procedure is considered a red rule, all clinicians must agree that such action is always expected. Again, leaders must be willing to hold clinicians who breach the red rule accountable for their behavioral choices and support staff members who halted progression of the procedure. Other examples of red rules in the operating room include using sterile surgical instruments in open incisions (no one would condone picking up an instrument that dropped on the floor and using it again) and the wearing of masks, gowns, and gloves during a surgical procedure. Organizations must also hold staff members accountable for their behavioral choices and must fairly assess the reason they chose not to stop the line when a red rule was breached.

MISUSE OF RED RULES IN HEALTH CARE

Some health care organizations have adopted red rules in order to improve

compliance with rules that are often broken for various reasons, many of them rooted in inadequate system support for following the rule. For example, a red rule stating that health care practitioners should always follow the “five rights” would not be appropriate. Red rules should not be confused with organizational policies or standard operating procedures, even essential ones, such as handwashing, that call for strict adherence.²

Although compliance with policies and procedures is always expected, there are times when practitioners cannot adhere to the rules or circumstances and when violating a rule might be the best course of action. In an environment where bar-coding technology is available, policies and procedures that call for practitioners to scan all medications before dispensing or administering them would certainly be considered crucial. However, sometimes scanning is not possible because of technology glitches, product idiosyncrasies, or emergencies. Thus, compliance with bar-coding technology cannot be considered a red rule unless the organization has processes in place to ensure that not scanning a medication is a rare event and that anyone can stop the line when the scanning doesn't occur.

Implementing too many red rules is another problem; it is generally difficult for staff to remember the rules, follow them at all times, and stop the line whenever a rule is broken. Red rules are meaningless and fail to achieve the goal of safety if they are applied to situations that are more appropriate for standard operating procedures.² Relying on too many red rules can also lead to rule-dependent behavior in which health care professionals do not feel obligated or permitted to think critically about patient care and safety outside the established rules.¹

CONCLUSION

When an organization is deciding whether to adopt red rules, an interdisciplinary team, including representatives from senior leadership and medical staff, should carefully consider each suggested rule to ensure that it meets the criteria described earlier. If properly implemented, red rules have the potential to promote an organizational culture of

safety that shares accountability for the safe delivery of patient care. However, if red rules are misused or poorly supported by organizational leadership and the workforce, they cannot be effective and may even increase patient risks if systems and processes are not in place to facilitate staff adherence to the rules.

REFERENCES

- 1 Griffith S. An examination of red rules in a just culture. November 28, 2007. The Just Culture Community (administered by Outcome Engineering, LLC). Available at: www.justculture.org/newsletters.aspx?id=8#2. Accessed December 2, 2011.
- 2 Scharf WR. Red rules: An error-reduction strategy in the culture of safety. *Focus Patient Saf* 2007;10(1):1–2.

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